Scala Naturae
INTEGRATIVE HEALTH

Primary Care New Patient Intake Packet

Please complete this packet before your appointment. Check every disease, condition, or symptom that applies to you. Use the fillable fields to provide additional details. If a section does not apply, write N/A. Do not email protected health information; submit through the secure portal or clinic-approved upload process.

Patient Attestation

I certify that the information provided is accurate and complete to the best of my knowledge. I understand this information will be used to support safe, individualized care.

Electronic Signature: _____ Date: _____

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1. Patient Registration & Demographics

Legal Name

Preferred Name

Date of Birth

Sex Assigned at Birth

Gender Identity

Pronouns

Address

City/State/ZIP

Mobile Phone

Alternate Phone

Email

Preferred Language

Emergency Contact

Emergency Contact Phone

Preferred Pharmacy

Pharmacy Phone

Insurance / Medicare / Medicaid

Primary Insurance

Member ID

Group Number

Medicare ID

Medicaid ID

Policyholder Name

Electronic Signature:

Date:

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2. Chief Complaint & History of Present Illness

Reason for Today's Visit

Date Symptoms Started

Severity 0-10

What Makes It Worse?

What Makes It Better?

Patient Goals / Additional Details
Prior Evaluation/Treatment

Electronic Signature:

Date:

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3. Past Medical History

Check all diagnosed conditions you have or have had:

- ☐ Hypertension
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Prediabetes
- ☐ High Cholesterol
- ☐ Coronary Artery Disease
- ☐ Heart Failure
- ☐ Atrial Fibrillation
- ☐ Heart Murmur
- ☐ Stroke/TIA
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ GERD/Reflux
- ☐ IBS
- ☐ Thyroid Disease
- ☐ Obesity
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Chronic Pain
- ☐ Migraine
- ☐ Seizures
- ☐ Cancer
- ☐ Anemia
- ☐ Blood Clots
- ☐ Depression
- ☐ Anxiety
- ☐ PTSD
- ☐ ADHD
- ☐ Bipolar Disorder
- ☐ Autoimmune Disease
- ☐ Other

Other Conditions / Diagnosis Dates / Specialists

Electronic Signature: Date:

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4. Surgical History

List all surgeries/procedures. Include approximate date if exact date is unknown.

Procedure	Date	Hospital/Facility	Complications

Electronic Signature: Date:

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5. Family History Grid

Check conditions that apply to your family history:

	Mother	Father	Sibling	Child	Grandparent	Other
Hypertension	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Substance Use Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐

Details, Ages, Type of Cancer, Other Family History

Electronic Signature: Date:

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6. Social History & Social Determinants of Health

Check any current concerns:

- ☐ Housing instability
- ☐ Transportation difficulty
- ☐ Safety concerns at home
- ☐ Limited social support
- ☐ Childcare concerns
- ☐ Food insecurity
- ☐ Financial strain
- ☐ Difficulty paying for medications
- ☐ Employment concerns
- ☐ Health literacy concerns

Social History

Tobacco Use

Alcohol Use

Recreational Drug Use

Exercise

Diet/Nutrition

Occupation

Electronic Signature:

Date:

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7A. Review of Systems: General / HEENT / Cardiac

Check any symptom you currently have or have recently experienced:

- ☐ Fever
- ☐ Fatigue
- ☐ Weight Gain
- ☐ Vision Changes
- ☐ Hearing Loss
- ☐ Sinus Problems
- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Chills
- ☐ Night Sweats
- ☐ Weight Loss
- ☐ Eye Pain
- ☐ Ear Pain
- ☐ Sore Throat
- ☐ Palpitations
- ☐ Fainting

Comments / Details

Electronic Signature:

Date:

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7B. Review of Systems: Respiratory / GI / GU

Check any symptom you currently have or have recently experienced:

- ☐ Cough
- ☐ Shortness of Breath
- ☐ Abdominal Pain
- ☐ Vomiting
- ☐ Constipation
- ☐ Blood in Stool
- ☐ Urinary Frequency
- ☐ Blood in Urine
- ☐ Wheezing
- ☐ Snoring
- ☐ Nausea
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Painful Urination
- ☐ Urinary Urgency
- ☐ Pelvic Pain

Comments / Details

Electronic Signature:

Date:

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7C. Review of Systems: MSK / Neuro / Psych / Skin / Endocrine

Check any symptom you currently have or have recently experienced:

- ☐ Joint Pain
- ☐ Muscle Weakness
- ☐ Headache
- ☐ Numbness/Tingling
- ☐ Memory Problems
- ☐ Anxiety
- ☐ Rash
- ☐ Hair Loss
- ☐ Excessive Thirst
- ☐ Back Pain
- ☐ Falls
- ☐ Dizziness
- ☐ Seizures
- ☐ Depression
- ☐ Insomnia
- ☐ Itching
- ☐ Heat/Cold Intolerance
- ☐ Easy Bruising

Comments / Details

Electronic Signature:

Date:

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8. Medication Reconciliation

List all prescription medications, over-the-counter medications, vitamins, and supplements.

Medication Name	Dose	Frequency	Reason/Prescriber

Additional Medications / Notes

Electronic Signature:

Date:

9. Allergies

Allergen	Reaction	Severity	Date/Notes

Electronic Signature: Date:

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10. Preventive Care & Medicare Annual Wellness

Check completed items or concerns that apply:

- ☐ Flu vaccine
- ☐ COVID vaccine
- ☐ Pneumonia vaccine
- ☐ Tdap
- ☐ Shingles vaccine
- ☐ Colonoscopy/Cologuard
- ☐ Mammogram
- ☐ Pap smear
- ☐ Bone density
- ☐ Eye exam
- ☐ Dental exam
- ☐ Advance directive
- ☐ Fall in past year
- ☐ Uses assistive device
- ☐ Memory concerns

Last preventive exam

Specialist visits

Functional limitations

Caregiver concerns

Electronic Signature: Date:

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11. PHQ-9 Depression Screening

Mental health is an important part of overall wellness. Please answer honestly so your provider can understand symptoms of depression and support your care.

Little interest or pleasure in doing things	
Feeling down, depressed, or hopeless	
Sleep problems	
Feeling tired	
Poor appetite or overeating	
Feeling bad about yourself	
Trouble concentrating	
Moving/speaking slowly or being fidgety	
Thoughts of self-harm	

Total Score:

Electronic Signature:

Date:

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12. GAD-7 Anxiety Screening

Anxiety symptoms can affect daily functioning and quality of life. Please complete this screening to help us evaluate anxiety-related concerns.

Feeling nervous, anxious, or on edge	
Not being able to stop or control worrying	
Worrying too much about different things	
Trouble relaxing	
Being so restless it is hard to sit still	
Becoming easily annoyed or irritable	
Feeling afraid as if something awful might happen	

Total Score:

Electronic Signature:

Date:

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13. AUDIT-C / DAST-10 Substance Use Screening

These screening questions help identify alcohol or substance use patterns that may affect your health. Your responses are confidential and used to guide care.

AUDIT-C Q1

AUDIT-C Q2

AUDIT-C Q3

DAST-10 Total Score

Substance Use Details

Electronic Signature:

Date:

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14. Minnesota Telehealth Consent

Telehealth services are delivered through secure electronic communication when clinically appropriate. By participating, you acknowledge that telehealth has benefits and limitations, including possible technology failures and privacy risks. You agree to participate from a private location, provide your physical location during the visit, and seek emergency care by calling 911 or going to the nearest emergency department if needed. You may request in-person care when appropriate.

- ☐ I consent to receive telehealth services.
- ☐ I understand technology limitations and privacy risks.
- ☐ I understand SNIH does not provide emergency services through telehealth.
- ☐ I agree to provide my physical location during each telehealth visit.

Electronic Signature: _____ Date: _____

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15. HIPAA Privacy Acknowledgment

Scala Naturae Integrative Health is committed to protecting the privacy and security of your health information. Your protected health information may be used or disclosed for treatment, payment, healthcare operations, and as otherwise permitted or required by law. You have rights related to your health information, including the right to request access, amendments, restrictions, and confidential communications as described in the Notice of Privacy Practices.

☐ I acknowledge receipt or access to the Notice of Privacy Practices.

Electronic Signature: _____ Date: _____

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16. Financial Policy

Patients are responsible for applicable copayments, deductibles, coinsurance, self-pay fees, non-covered services, and balances not paid by insurance. Payment may be due at the time of service unless prior arrangements are made. Missed appointments or late cancellations may be subject to a no-show or cancellation fee. Insurance benefits are not a guarantee of payment.

- [ ] I understand my financial responsibility.
- [ ] I understand insurance may not cover all services.
- [ ] I understand cancellation/no-show policies may apply.
- [ ] I agree to provide accurate insurance information.

Electronic Signature: _____ Date: _____

17. Release of Information

Release Records From

Release Records To

Purpose of Disclosure

Information to Release

Expiration Date

Electronic Signature:

Date:

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18. CharmHealth Questionnaire Mapping

Patient Registration	Demographics + Insurance + Preferred Pharmacy
Chief Complaint & HPI	Reason for visit + symptom timeline + patient goals
PMH	Condition checkboxes + diagnosis details
Surgical History	Procedure/date/facility/complications table
Family History	Family condition grid
Social History & SDOH	Lifestyle + social needs
ROS	System-based symptoms
Medication Reconciliation	Medication/dose/frequency/reason table
Allergies	Allergen/reaction/severity table
Preventive/AWV	Preventive care + Medicare wellness items
PHQ-9/GAD-7/AUDIT-C/DAST-10	Screening score fields
Consent Packets	Telehealth, HIPAA, financial policy, ROI

Electronic Signature: Date: